93-655

No.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

EVANSTON HOSPITAL,

Petitioner,

v.

ROBERT V. HAUCK, LOUIS W. SULLIVAN, Secretary of the United States Department of Health and Human Services, PHILLIP BRADLEY, Director of Illinois Department of Public Aid, and CORBOY & DEMETRIO, P.C.

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

I. WHETHER TITLES XIX OF THE SOCIAL SECURITY ACT PROHIBITS A MEDICAID PROVIDER FROM REFUNDING A MEDICAID PAYMENT WHEN A THIRD-PARTY HAS SUBSEQUENTLY BEEN DETERMINED LIABLE ON THE CLAIM.

II. WHETHER THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE ILLINOIS DEPARTMENT OF PUBLIC AID EXCEEDED THEIR STATUTORY AUTHORITY IN REFUSING TO ACCEPT PROVIDER REFUNDS OF PRIOR MADE PAYMENTS FOR MEDICAL ASSISTANCE ON BEHALF OF TITLE XIX MEDICAID RECIPIENTS WHERE IT ACCEPTS PROVIDER REFUNDS OF TITLE IV-D CLAIMS AND REIMBURSEMENT ON TITLE IV-D AND TITLE XIX CLAIMS ARE GOVERNED BY THE SAME CONGRESSIONAL STATUTE.

SUPREME COURT RULE 29.1 STATEMENT

The Appellant, Evanston Hospital, is a not-for-profit hospital corporation.

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PETITION FOR WRIT OF CERTIORARI

Evanston Hospital respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

REFERENCE TO REPORTS AND OF OPINIONS

This action was filed in the United States District Court for the Northern District of Illinois under case number 92 C 0732. An opinion was issued on August 19, 1992.

This opinion is reproduced at pages 9-14 of the Appendix.

Plaintiff sought review in the United States Court of Appeals for the Seventh Circuit under case number 92-3551. The Court of Appeals decision was published in the Federal Reports at 1 F.3d 540 (7th Cir. 1993) and is reproduced at pages 1-7 of the Appendix.

STATEMENT OF JURISDICTION

This Petition for Writ of Certiorari is filed pursuant to 28 U.S.C. §1254(1) seeking review of the Opinion issued by the United States Court of Appeals for the Seventh Circuit on July 30, 1993 affirming the Order dismissing Plaintiff's complaint entered by the United States District Court for the Northern District of Illinois. Jurisdiction over this action in the District Court was granted pursuant to 28 U.S.C. §1331 and the Court was empowered to award the relief requested pursuant to that statute and 28 U.S.C. Federal Rules of Civil Procedure, Rule 57.

STATUTES AND OTHER LAWS INVOLVED

This case concerns the issue of whether the Illinois Public Aid Code, Ill. Rev. Stat. ch. 23, par. 1, *et seq.* conflicts with Title XVIII of the Social Security Act, 42 U.S.C. §1396, *et seq.* The relevant provision of both Acts are set forth at pages 9-21 of the Appendix.

STATEMENT OF THE CASE

A. Nature of the Controversy

Robert V. Hauck after sustaining an electrical injury was hospitalized at Evanston Hospital for over a year. While receiving medical and hospital treatment, Robert Hauck incurred hospital charges of $270,760.24. As Mr. Hauck did not have any health insurance coverage, a claim

was filed with the Illinois state medicaid agency, the Illinois Department of Public Aid ("IDPA"). Since at the time the claim was filed, no other third-party was apparently liable for the payment of the claim, the IDPA paid $113,424.00 under the Medicaid program.

Robert Hauck filed a personal injury action seeking to recover damages for the injuries which necessitated his hospitalization. Among the damages for which he sought compensation was his hospital bill of $270,760.24, the amount the Illinois Hospital Lien grants Evanston Hospital the right to recover from a personal injury action; and not, the $113,424.00 the IDPA paid on the claim for which it has right to repayment. 305 ILCS 5/11-22. In his personal injury action, Robert Hauck recovered $9.6 million.

B. The Proceedings Below

Plaintiff filed a declaratory judgment action seeking a declaration that the IDPA's Medicaid program policy of refusing to accept provider refunds when third-parties are found liable subsequent to Medicaid payments and the United States Department of Health and Human Services ("HHS") approval of that policy is without statutory authority and conflicts with Title XIX of the Social Security Act. Plaintiff also sought a declaration that HHS' policy of refusing to accept a provider refund of Medicare payment when a third-party is determined liable on the claim subsequent to a Medicare payment violates the Medicare Secondary Payor provision of Title XVIII of the Social Security Act. Finally, Plaintiff also sought a declaration of its hospital lien rights under the Illinois Hospital Lien Act, 770 ILCS 35/1 (1993).

The United States District Court for the Northern District of Illinois dismissed all counts of Plaintiff's complaint. Appendix, page 14.

On appeal to the United States Court of Appeals for the Seventh Circuit, the Court affirmed the dismissal of Plaintiff's complaint in a decision issued July 30, 1993. Appendix, page 8.

Plaintiff's submission of this Petition for a Writ of Certiorari followed.

REASONS FOR GRANTING THE WRIT

This case presents an important and frequently recurring question regarding federal statutory interpretation on the rights of medical providers under the Medicaid program which would have a significant impact on Medicaid financing at the federal and state level and the impairment of the state granted rights of medical providers. Specifically, it questions the government respondents statutory authority to refuse to accept a Medicaid provider refund.

THE ILLINOIS STATE MEDICAID AGENCY AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES HAVE EXCEEDED THEIR STATUTORY AUTHORITY UNDER THE SOCIAL SECURITY ACT BY REFUSING TO ACCEPT PROVIDER REFUNDS OF MEDICAID PAYMENTS WHEN A THIRD-PARTY HAS SUBSEQUENTLY BEEN DETERMINED LIABLE FOR MEDICAL SERVICES RENDERED A MEDICAID BENEFICIARY.

A. The Seventh Circuit Court's Opinion Fails To Enforce The Requirement Of The Social Security Act That The Medicaid Program Not Pay Any Claim Where A Third Party Is Liable.

The court below erroneously stated that the federal statutes cited by the hospital "do not actually say that Medicaid must be the payor of last resort. Indeed, at no point in the law governing Medicaid are states directed not to

pay for services where the patient is or may be entitled to payments by a third party." 1 F.3d at 543, App. 3. In reaching this decision, the court below failed to recognize that there are express requirements imposed by both the Social Security Act and their implementing regulations which specifically limit a state from paying for Medicaid claims where a third party is found liable on the claim. 42 U.S.C. §1396a(25); 42 C.F.R. §433.139. Additionally, the Seventh Circuit Opinion ignores the entire express purpose of the Medicaid program and the purpose behind the payor of last resort provision.

The Medicaid program was established by Title XIX of the Social Security Act ("the Act") and provides medical assistance to certain low-income individuals. 42 U.S.C. §1396, *et seq.* It is administered by the States in accordance with federal requirements elucidated in the Act and promulgated in regulation by the Secretary of Health and Human Services. 42 U.S.C. §1396a. Pursuant to the Act, the Medicaid program is intended to be the payor of last resort. 42 U.S.C. §1396a(25). As the payor of last resort, all of the available third-party resources must be used before liability rests with the Medicaid program. 42 C.F.R. §433.139. Proceeds from a liability insurance policy, as in the Hauck Personal Injury action, are considered available third-party resources. 42 C.F.R. §433.139(b)(1), 447.20, *et seq.* (1990).

As a result of the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), HHS, through the Health Care Financing Administration, issued new regulations governing the State Medicaid Programs' treatment of third-party liability. *See* 55 Fed. Reg. 1423 (1990). In promulgating these regulations, HHS noted that §1903(o) of the Act, prohibits federal matching funds of state Medicaid payments "if its private insurer would have

been liable to pay for the medical care under its policy. 42 U.S.C. §1396b(o). HHS noted:

> [T]he overall purpose of State Medicaid third-party liability (TPL) program is to ensure that Federal and State funds are not misspent for covered services to eligible Medicaid recipients when third parties exists that are legally liable to pay for those services.

55 Fed. Reg. 1423, *reprinted in* [1990 Transfer Binder] Medicare and Medicaid Guide (CCH) par. 38, 336.

With the promulgation of these regulations, HHS promulgated a new regulation which provided that where a Medicaid covered service was found to be the legal liability of a third party, then a provider who receives a greater payment from the third party, then the amount which would have been payable by Medicaid, is prohibited from seeking to collect from the Medicaid recipient or "any financially responsible relative or representative of the individual" any additional payment amount. 42 C.F.R. §447.20. The aforementioned regulation limiting provider's recovery to the amount of an insurance payment where that insurance payment exceeds the amount which Medicaid was potentially liable to pay, constituted HHS' regulatory implementation of the Title XIX requirements that a Medicaid payment be considered payment in full. This regulation allows the provider to pursue the full extent of a third party's liability and only prohibited the provider from pursuing any additional payment from the recipient. In promulgating this regulation, HHS gave full force and effect to both the Payor of Last Resort and Payment in Full provisions without impairing a medical providers statutory or contractual rights. At the time that the final regulations were adopted, HHS responded to a Comment which raised the issue of whether under the new regulations, a provider was prohibited from pursuing reimbursement of its charges from an insurance policy.

> **Comment**: One comment interpreted the provider restriction against seeking to collect amounts from a representative of the individual, as a restriction against seeking to collect amounts from the individual's insurance and questioned why the provider cannot receive amounts from the resources available to the recipient.

55 Fed. Reg. 1423, *reprinted in* [1990 Transfer Binder] Medicare and Medicaid Guide (CCH), par. 38, 336.

HHS, in responding to this Comment, noted that the provider was not prohibited from pursuing a third party resource stating:

> **Response**: The intent of this provision is to protect the Medicaid recipient from being charged for a service in excess of the amounts allowed under the State plan *after considering the third party's liability*. The phrase representative of an individual refers to a legal representative of an adult who has been determined incompetent or is incapable of handling his or her own affairs. §433.139(b)(1) requires a provider to determine the amount of liability from any third party, as defined in *that* section. *The provider is not restricted from receiving amounts from third party resources available to the recipient (or his or her legal representative).*

Id. (emphasis added).

With the promulgation of these regulations as explained by the comments accompanying the publication of the Final Rule, HHS has harmonized and implemented two statutory directives of Title XIX of the Act. Namely, that Medicaid is the payor of last resort and that a Medicaid payment, or the payment by a liable third party of an amount in excess of the Medicaid payment, constitutes payment in full of any claim.

Neither the Social Security Act nor HHS' regulations expressly address the situation of the provider's rights where a third party is adjudicated liable for the medicaid beneficiary's medical bills subsequent to the payment of the claim by the state medicaid agency. The Court below erroneously found that the provider's statutory rights and contractual rights to reimbursement were extinguished by accepting the Medicaid payment. 1 F.3d 543-44, App. 5. The Court below has given full force and effect to the Medicaid payment in full provision and has attempted to also implement the Payor of Last Resort provision. Relying upon 42 U.S.C. §1396(a)(25)(B) which states in part:

> where such legal liability is found to exist after medical assistance has been made available on behalf of the individual . . . the State or local agency to the extent of such legal liability.

The Court found that the phrase "will seek reimbursement" means that State reimbursement must be sought from the liable third party. State reimbursement, however, may also be accomplished by a provider refund. A provider refund is consistent with the express language of the Act assuring state reimbursement with a minimal cost, it assures that the liable party pays the claim for which it is liable and it does not invade the provider's statutory or contractual rights. Additionally, since the amount the provider could recover would be limited to the amount recoverable from the liable third party, the Payment in Full protection granted the Medicaid beneficiary is also fully intact.

B. The Seventh Circuit Court's Opinion Erroneously Assumed That The State Agency Reimbursement Must Come From A Liable Third Party And Not Through A Provider Refund.

The Court below erred in assuming that the only manner in which reimbursement of a state medicaid agency for payment made on a Medicaid claim where a third party has subsequently been determined liable is through the state agency pursuit of the third party. 1 F.3d at 543-44, App. 5-7. The express language of the relevant section of the Act does not state the manner in which reimbursement should be sought, does not state from whom the state agency may accept reimbursement nor does it prohibit provider refunds.

In the rulemaking process accompanying the publication of the final Payor of Last rules, HHS addressed the appropriateness of provider refunds. That is, how does the provider procedurally handle a payment from a third party once the claim has been billed to Medicaid.

> **Comment**: One comment asked what providers or recipients should do if they receive payment on a Title IV-D claim from a liable third party after Medicaid is billed.
>
> **Response**: The recipient must reimburse the Medicaid State Agency for the amount the Medicaid Agency paid for medial expenses. . . *The provider is also required to reimburse Medicaid in connection with medicaid covered services that the provider has furnished.* At State option, the provider may either return to the Medicaid Agency the amount Medicaid paid or may contact the Medicaid Agency, which will in turn offset the amount against future Medicaid payments to the provider.

55 Fed. Reg. 1423, *reprinted in* [1990 Transfer Binder] Medicare and Medicaid Guide (CCH), par. 38,336 (emphasis added).

In the above-quoted Comment and Response, HHS has clearly delineated the procedures by which the State Medicaid Agency and the provider handle Medicaid claims in the situation of a potentially liable third party. If subsequent to being paid by Medicaid, the provider is paid by a third party who is liable for the claim, the HHS; comment response clearly indicates that the provider must refund and the State Medicaid Agency must accept, the earlier improperly paid Medicaid payment. The only option available to the State Medicaid Agency, is not whether or not to accept the refund, this is required by statute and regulation, but rather is the manner of the refund, be it an actual physical refund or as an offset against future Medicaid payments.

While the above-quoted Comment and Response is cast in terms of a payment made on a Title IV-D claim, the statutory section governing reimbursement of improperly paid Title IV-D is the same section which governs reimbursement in the instant action. The only federal statutory authority which governs reimbursement to the state Medicaid agency in the situation where the third party payment is from a liability insurer, is the same relevant subparagraph (B) of 42 U.S.C. §1396a(a)(25) which governs reimbursement of Title IV-D claims.

Neither section 1396a(a)(25)(B), nor any other section of Title XIX of the Act authorizes the existence of a state Medicaid plan or provides authority to a state Medicaid agency to distinguish whether or not it will accept provider refunds based upon the nature of the third party liability payment. The Defendants current policy of refusing to accept Medicaid provider refunds is a result of an administrative agency interpretation that is unsupported by the Social Security Act. That interpretation and the resulting policy unlawfully impairs the providers state

granted and contractual rights where no authority for such impairment exists in the Act.

The Illinois Hospital Lien Act grants not-for-profit hospitals a lien on any liability settlement or award. 770 ILCS 35/1 (1993). Nowhere in the Social Security Act does Congress give the State Medicaid Agency or HHS the authority to extinguish a hospital's lien right. These rights, however, have been extinguished as a result of the administrative agency policy prohibiting provider refunds.

The Court below also miscast Plaintiff's position stating it wished to "still retain the right to sue patients who later become solvent. . ." 1 F.3d at 543, App. 5-6. Plaintiff acknowledges that any Medicaid beneficiary cannot be sued or even asked for payment by the provider for any Medicaid covered charges. Plaintiff does not seek to pursue the Medicaid patient, but rather seeks to exercise its state granted hospital lien rights against a liable third party. The Social Security Act does not prohibit the exercise of this right against liable third parties. The Illinois Public Aid Code, however, as presently being interpreted, prohibits the exercise of those lien rights.

If a provider refunds a Medicaid payment, the Payment in Full provision is still applicable and a provider may not sue or pursue a Medicaid beneficiary. Rather, the provider is pursuing the liability insurer which is fully consistent with the Medicaid Payor of Last Provision.

Both Courts below also misunderstand the reality of provider treatment of patients and reimbursement in the current health care environment. As a not for profit organization, Plaintiff is obligated to treat patients such as Mr. Hauck without regard to the patient's ability to pay.

The Court below expressed the fear that allowing provider refunds would bankrupt the Medicaid system "because hospitals would have every incentive to capture as much government money as they could without regard for the probabilities of collecting reimbursement from the private party." 1 F.3d at 544, App. 6. This opinion misunderstands the current predicament of not for profit health care institutions when dealing with a potential liability payment. With the backlog of cases in the judicial system, it may take up to seven years after a hospital renders treatment to a tort victim, before the liability of an insurer is established. Accompanied by the right to appeal a trial court's verdict, adjudication of a third party's liability could easily last over a decade. Forced with a choice of potentially waiting in excess of ten years for payment of a claim from a liability insurer or current payment from the Medicaid system, providers rarely choose to forgo the Medicaid payment. Given the providers absence of any control over whether the tort victim actually pursues a personal injury action as well as its obvious inability to control the course of the personal injury action or even evaluate its potential for success, the filing of a claim with the Medicaid system or waiting for others to decide whether to pursue a personal injury action is really an illusory choice. Providers will and do file claims with the Medicaid system routinely.

Allowing provider refunds is not as likely to bankrupt the already financially troubled Medicaid system as it is likely to bring the resources of hospitals to assuring that liable third parties pay claims on which the Medicaid system erroneously paid. If anything, provider refunds will generate the return of more Medicaid dollars as the institutions with the incentive and resources pursue their statutory and contractual rights.

The present administrative interpretation, aside from being unsupported by any express statutory authority, also results in a windfall to Medicaid beneficiaries at expense of medical providers. As stated above, medical providers in reality are not in a position to actually choose between Medicaid reimbursement and awaiting a potential personal injury award. As a result, providers must accept a significantly reduced payment of its charges if it hopes to obtain any reasonable compensation. The liability insurer, however, compensates the Plaintiff-Medicaid beneficiary at the much higher total charges of the hospital bill and not the lower medicaid rate which must be reimbursed to the state medicaid agency. The result of this policy is that while the total cost of hospitalization is paid as part of the liability settlement by the liability insurer, since only the medicaid payment must be refunded, the medicaid beneficiary receives a windfall in the form of the difference in those amounts. In the instant action, an excess of $150,000 in a windfall payment is given to the Medicaid beneficiary and the provider who rendered services and who the state has stated via the Illinois Hospital Lien Act is entitled to payment from the liability insurer must fund this windfall to the beneficiary. The Seventh Circuit Court erroneously stated that Petitioner seeks "to turn Medicaid upside down by converting the system into an insurance program for hospitals. . . ," 1 F.3d at 544, App. 5, when in reality the present administrative interpretation, now affirmed by the Seventh Circuit Court of Appeals, creates a windfall insurance program for Medicaid beneficiaries. This result was clearly not envisioned by Congress in enacting the Act.

The present policy of prohibiting provider refunds of Medicaid payments conflicts with the purpose of Medicaid program, is unsupported by the express language of the

Act, is internally inconsistent based upon the nature of the third party payment where such inconsistency is unsupported by the Act, and results in an inappropriate windfall to Medicaid beneficiaries at the expense of Medicaid providers which result is also not consistent with the Social Security Act.

CONCLUSION

For the foregoing reasons, this Court should grant petitioner's request for a writ of certiorari to review the decision of the Seventh Circuit Court of Appeals.

Respectfully submitted,

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APPENDIX

IN THE
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FOR THE SEVENTH CIRCUIT

No. 92-3551

EVANSTON HOSPITAL,

Plaintiff-Appellant,

v.

ROBERT V. HAUCK, LOUIS W. SULLIVAN, Secretary of the United States Department of Health and Human Services, PHILLIP BRADLEY, Director of Illinois Department of Public Aid, et al.,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 92 C 732—**Harry D. Leinenweber,** *Judge.*

ARGUED MAY 7, 1993—DECIDED JULY 30, 1993

Before BAUER, *Chief Judge,* and CUMMINGS and EASTERBROOK, *Circuit Judges.*

CUMMINGS, *Circuit Judge.* After coming in contact with a live electrical wire, Robert V. Hauck landed in Evanston Hospital and stayed there for more than a year, running up a bill of $270,760.24. He could not pay it and apparently did not have private health insurance to pay it for him. The hospital decided to accept partial reimbursement of $113,424 from Medicaid, the government-run health care insurance program for indigents, which in Illinois is administered by the state Department of Public Aid ("IDPA").

The hospital's acceptance of the money from Medicaid was conditioned on the understanding that it would be payment in full—whatever claims the hospital might have had against Hauck were relinquished to IDPA. Then Hauck won a $9.6 million judgment in a lawsuit stemming from his accident. Hauck's newfound wealth caused Evanston Hospital to regret the deal it had made with Medicaid. The hospital now wants to give back to IDPA the $113,424 it earlier accepted as payment in full so that it can sue Hauck for the $270,760.24 it originally sought. The hospital attempts to justify reneging on its agreement with IDPA by claiming that Illinois law is in conflict with federal law. It isn't. The district court dismissed the hospital's suit for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) and we affirm.

Under Illinois law, when Medicaid pays money to a hospital on behalf of an individual, it "shall constitute payment in full for the goods or services covered thereby. Acceptance of the payment by or on behalf of the vendor [hospital] shall bar him from obtaining, or attempting to obtain, additional payment therefor from the recipient or any other person." 305 ILCS 5/11-13.[1] The Illinois Administrative Code states the rule explicitly: "The provider [hospital] shall agree to * * * [A]ccept as payment in full the amounts established by [IDPA] * * *." Ill. Admin. Code tit. 89, § 140.12(h) (1993).

Evanston Hospital first argues that by refusing to accept its offer of a refund, IDPA has forced the hospital to abandon its lien on Hauck's property. But Evanston Hospital was not "forced" to abandon its right to sue Hauck; no one coerced the hospital into cashing a $113,424 check from the taxpayers as partial reimbursement for Hauck's medical bills. Rather, the hospital could have simply forsaken Medicaid and taken its chances that Hauck would somehow come up with the money to pay the bills himself.

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[1] This provision used to be numbered as Ill. Rev. Stat. 1991, ch. 23, § 11-13.

By opting for reimbursement from Medicaid, Evanston Hospital bought certainty. It purchased a guarantee of partial payment in lieu of possibly full payment or possibly no payment at all. Risk-averse companies that are owed money (or which do not want the hassle) make this same deal all the time with collection agencies—something secure is traded for a crack at a higher sum. Evanston Hospital wants out of its agreement with Medicaid now only because its gamble, in retrospect, was unwise.

Evanston Hospital's position would not be so far-fetched if it could prove that its contract with IDPA were somehow invalid—say, if it were against public policy. Thus plaintiff argues that Illinois law and procedures regarding Medicaid conflict with federal law, are invalid and should not be enforced. As best we can discern from the hospital's briefs and from the position taken by counsel at oral argument, Medicaid must be the payor of last resort; that is, Medicaid can only pay a medical bill when every other possible source has been exhausted. Here, since it was later determined that Hauck himself could pay because of his multi-million dollar tort judgment, IDPA should not have reimbursed Evanston Hospital. And if IDPA should never have paid Evanston Hospital, then of course there is no harm in allowing the hospital to refund IDPA's money so that it can sue Hauck. In plaintiff's view, the Illinois law requiring hospitals to accept money from Medicaid only as full and final payment is in conflict with the federal requirement that Medicaid be the payor of last resort. It posits that the only way to resolve the conflict is to rewrite the Illinois Medicaid law—by reinterpreting the phrase "any other person" to exclude third parties—to allow hospitals and other providers to go after proceeds from tortfeasors even after the providers have accepted government reimbursement.

The logic behind this argument is elusive. First, the federal statutes cited by the hospital do not actually say that Medicaid must be the payor of last resort. Indeed, at no point in the law governing Medicaid are states directed not to pay for services where the patient is or may be

entitled to payments by a third party. Plaintiff, for example, cites 42 U.S.C. § 1396b(*o*), but this provision only says that a state should not pay medical bills where a private insurer would normally be responsible except for a clause in the insurance contract excusing the company's obligations if the government will pay instead. This provision is merely designed to keep insurance companies from shifting responsibility onto the government by contractual fiat, and is utterly inapplicable to these circumstances where Hauck did not even have private insurance. Evanston Hospital's brief cites other administrative commentaries but these are similarly beside the point.

In any event, Medicaid was the payor of last resort at the time Hauck's medical bills came due. Hauck was released from the hospital on November 14, 1986. It was not until December of 1991 that Hauck prevailed on his tort claim. When IDPA agreed to pay $113,424 for Hauck's care and Evanston Hospital agreed to accept that sum as total payment, Hauck's $9.6 million award was merely a gleam in the eye of a personal injury lawyer. Even if there were a payor-of-last-resort requirement in Medicaid law, it could not have the meaning plaintiff proposes because there will always be some possibility that an indigent patient will emerge victorious in a future lawsuit, win the lottery, strike gold, or land a good job and save some money. Under plaintiff's reading of Medicaid law, no state administrative agency could ever qualify as a Medicaid payor of last resort because alternative sources of reimbursement might later emerge.

More to the point, Evanston Hospital misconstrues the notion of what it means to be a payor of last resort. To the extent such a concept is implicit in the federal statute, it means that the government itself should not be stuck paying medical bills when another source is available, not that hospitals and doctors should reap a windfall at the government's expense. Thus both federal and Illinois law agree that once Medicaid has paid for medical services, IDPA is obliged to vigorously pursue any third party who might bear some legal responsibility for footing the bill. Under federal law, a state must:

> take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan * * * [and] in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the cost of such recovery, *the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.*

42 U.S.C. § 1396(a)(25)(A)-(B) (emphasis added). The statute does not say anything about turning over this right of reimbursement to the hospitals and doctors who have already received some compensation for their services. Again, Congress' intent that state Medicaid agencies, not hospitals or doctors, seek reimbursement from third parties is evident in another section of the Medicaid statute that requires indigent recipients of benefits to assign to the government whatever rights they might have in payment for medical care from other sources. 42 U.S.C. §§ 1396a(a)(45) and 1396k(a). If this arrangement is not acceptable to doctors and hospitals, they should not take Medicaid money in the first instance.

Plaintiff's assertion that states may not condition Medicaid disbursements on the understanding that payments are full and final is directly contradicted by the federal statute: "[I]n the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the services may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of any amount for that service * * *." 42 U.S.C. § 1396(a)(25)(C). What Evanston Hospital seeks, then, is to turn Medicaid upside down by converting the system into an insurance program for hospitals rather than for indigent patients. It wants to be reimbursed when the patient is indigent

and still retain the right to sue patients who later become solvent—a classic example of wanting to both have and eat cake. The Medicaid system would go bankrupt in short order under this scenario because hospitals would have every incentive to capture as much government money as they could without regard for the probabilities of collecting reimbursement from the private party.

Hauck also received a few thousand dollars worth of outpatient services after his release from Evanston Hospital which were paid for not by Medicaid but by Medicare, the federally run health care insurance program for the elderly and disabled.[2] The Medicare law, unlike the Medicaid statute, forbids payment where a third party can reasonably be expected to make prompt payment. 42 U.S.C. § 1395y(b)(2). This is known as the Medicare Secondary Payer provision. Like Medicaid, however, once the government has paid, the hospital or doctor accepting the money agrees to abandon all rights to further payment. *Rybicki v. Hartley*, 792 F.2d 260, 262 (1st Cir. 1986). The Medicare Secondary Payer provision is intended to keep the government from paying a medical bill where it is clear an insurance company will pay instead. *Id.* The point is not to give doctors and hospitals an ongoing right to return Medicare's money when it becomes expedient. Here again, Evanston Hospital alleges that Medicare should not have paid Hauck's bill in the first instance because his lawsuit assured there would be future third-party payment. And if Medicare should not have paid the bill to begin with, Evanston Hospital contends there would be no harm in allowing it to refund the money to the government so that it can sue Hauck personally. The Medicare Secondary Payer

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[2] The parties dispute how much the hospital billed Medicare and how much the program paid. The amounts are not significant to our resolution of the issues in the case, although the Secretary of Health and Human Services contends that Medicare, which pays by the service rendered rather than the hospital's billing rate, actually paid Evanston Hospital more than requested because of the program's fixed reimbursement scheme.

provision does not apply in these circumstances, however, because a tort judgment five years in the future can in no sense be considered the kind of certain, prompt third-party payment Congress had in mind when it wrote the Medicare statute.

There is recourse against Hauck for the cost of his care, but the recourse belongs to the government, not to Evanston Hospital. It is true that under our decision today Hauck receives a windfall equal to the value of the medical care he received but for which the government did not pay. But someone was bound to receive a windfall in these circumstances, and Congress decided it should be the recipient of medical care, not the hospital.

The district court's judgment is affirmed.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

JUDGMENT – WITH ORAL ARGUMENT

Date: July 30, 1993

BEFORE:

Honorable WILLIAM J. BAUER, Chief Judge
Honorable WALTER J. CUMMINGS, Circuit Judge
Honorable FRANK H. EASTERBROOK, Circuit Judge

No. 92-3551

EVANSTON HOSPITAL,

Plaintiff-Appellant

v.

ROBERT V. HAUCK, LOUIS W. SULLIVAN, Secretary of the United States Department of Health and Human Services, PHILLIP BRADLEY, Director of Illinois Department of Public Aid, et al.,

Defendants-Appellees

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 92 C 732—Harry D. Leinenweber, Judge.

This cause was heard on the record from the above mentioned District Court, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by that the judgment of the District Court is AFFIRMED, with costs, in accordance with the decision of this court entered this date.

(1061-051993)

[Dated August 19, 1992]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

EVANSTON HOSPITAL, Plaintiff,	)	
v.	)	CASE NO. 92 C 732
ROBERT V. HAUCK, LOUIS SULLIVAN, Secretary of United States Department of Health and Human Services, PHIL BRADLEY, Director of Illinois Department of Public Aid, and CORBOY & DEMETRIO, Defendants.	)	JUDGE LEINENWEBER

MEMORANDUM OPINION AND ORDER

Plaintiff, EVANSTON HOSPITAL (the "hospital"), has brought suit seeking a declaratory judgment that it may enforce a hospital lien levied against a judgment awarded to its former patient, Robert Hauck ("Hauck"). Although the hospital accepted Medicare and Medicaid payments on Hauck's behalf, it now wishes to refund the payments and pursue Hauck for the entire value of the care provided. The case is now before the court on defendants' motions to dismiss.

BACKGROUND

The hospital treated Hauck from 1985 to 1986 after he came into contact with a live electrical wire. Hauck was unable to pay his $270,760.24 medical bill but was eligible

for Medicaid. The hospital ultimately billed and received $113,424 from the Illinois Department of Public Aid ("IDPA" pursuant to its administration to the Illinois Medicaid plan. After receiving the Medicaid payment, plaintiff served a hospital lien on the personal injury lawsuit Corboy & Demetrio ("Corboy") filed on Hauck's behalf. Plaintiff also received $1,111.50 from Medicare for related medical services it rendered to Hauck from 1987 through 1990.

In 1991, Hauck's lawsuit resulted in a $9.6 million award. Plaintiff then sought to repay the IDPA for its Medicaid contribution in order to pursue the full value of the medical care from the judgment. The IDPA refused to accept payment from the hospital but sought reimbursement for a declaratory judgment that it could repay IDPA and obtain full payment from Hauck and Corboy.

DISCUSSION

The court dismisses plaintiff's complaint. Plaintiff has failed to identify any conflict between state and federal law which could provide the basis for a claim. Illinois Medicaid law does not conflict with the federal Medicaid law or policy and cannot conflict with the Secondary Payor Provisions of federal Medicare law, that being a different program. Moreover, plaintiff has failed to state a colorable claim under Medicare.

Medicaid Claims

Under Illinois law, an IDPA payment to a Medicaid vendor constitutes payment in full. Ill.Rev.Stat., ch. 23 ¶11-13. The IDPA establishes the amount it will give the medical provider pursuant to set a payment schedule. Acceptance of the payment bars the vendor from obtaining or attempting to obtain additional payment from the patient or any

other person. *Id.* The hospital agreed to accept Medicaid payment at IDPA rates as payment in full when it contracted with the IDPA to be a participating vendor. 89 Ill. Admin. Code §140.12(h). Plaintiff was not required to seek payment from Medicaid and knew that the IDPA would not pay the full price of the care provided. Plaintiff, nevertheless, chose to obtain the guaranteed smaller payment rather than wait for the conclusion of Hauck's lawsuit when it might have received the full amount. The state Medicaid agency determined that no probable third party liability existed at the time of the claim and, therefore, made payment. Plaintiff attempts to avoid the conditions connected with accepting Medicaid disbursements.

Plaintiff's complaint alleges that the subject of this action is the:

> conflict between the law of the State of Illinois, and federal law, on the issue of whether or not a provider, having accepted Medicare or Medicaid funds (at the substantially discounted rate), can later receive full payment of charges from a liable third party, refunding the amounts received from the government.

Cmplt. ¶10. Federal regulations mandate that "a state plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency." 42 CFR 447.15. The Illinois-administered Medicaid plan exactly complies with the federal mandate. It states, "A vendor payment . . . shall constitute payment in full for the goods or services covered thereby. Acceptance of the payment by or on behalf of the vendor shall bar him from obtaining, or attempting to obtain, additional payment therefore from the recipient or any other person." Ill.Rev. Stat., ch.23, §11-13. There is no conflict between state and

federal Medicaid law and, therefore, no controversy for purposes of a declaratory judgment.

Plaintiff also suggests that the Illinois law, which bars a health care provider from seeking additional payment after accepting Medicaid funds, conflicts with (i) the Secondary Payor provisions of the federal Medicare Program, and (ii) the Federal policy that Medicaid only exists as a payor of last resort. Neither argument has merit.

The Illinois Medicaid statute cannot conflict with federal Medicare law. Medicare and Medicaid are entirely separate programs with different purposes and standards. Medicaid is governed by Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.*, while Medicare is governed by Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.* Federal Medicare enactments do not provide any mandates for state Medicaid practices. Plaintiff's attempt to treat a Medicare provision as part of the Medicaid statute is not appropriate. Plaintiff has not adequately raised a federal question with regard to Medicare. The court, therefore, must dismiss this claim for lack of subject matter jurisdiction. Federal Rule of Civil Procedure 12(b)(1).

Plaintiff next argues that the Health and Human Services policy, which forbids a hospital from refunding public money and obtaining third party reimbursement, conflicts with the statutory intent of making Medicaid a payor of last resort. Plaintiff suggests that newly available funds nullify the underlying justification for the Medicaid payments and hospital reimbursement is an appropriate remedy. The Medicaid statute, however, provides a system for reimbursement of funds which does not contemplate hospital repayment. Plaintiff invents reimbursement options that are unnecessary to the legislative scheme. The state

agency is required to seek repayment from third parties; it is not required to seek or accept repayment from the health-care provider.[1] Indeed, if it could accept such reimbursement, the portion of the statute mandating reimbursement from liable third parties would be rendered inoperative: "If the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, *the agency must seek recovery of reimbursement*" from the third party. 42 CFR 433.139 (emphasis added). If the court were to give effect to the statute and allow Medicaid to accept a refund from the hospital, it would result in a double recovery for Medicaid. Moreover, to do so, the court would need to ignore the federal and state requirements that Medicaid providers not pursue patients for additional payments after receiving Medicaid funds.

When the hospital decided to collect its fees, no third party resources were available. Any proceeds from the lawsuit were entirely speculative. Medicaid was properly a payor of last resort and paid the bill according to its payment schedule. Plaintiff accepted it as payment in full pursuant to its agreement with the IDPA. There is no conflict between a federal policy that dictates what conditions exist before a vendor may seek payment and an Illinois law that dictates what restrictions exist after a vendor accepts payment.

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[1] Plaintiff's argument turns Medicaid on its head. Medicaid is not intended to benefit health-care providers, but patients. Although Medicaid is not designed to benefit health-care providers, Plaintiff reads the statute to give a hospital the *option* of making repayment if this were in its best interest. Such a policy would not only conflict with the language of the statute but would make Medicaid uncertain of where to turn for repayment.

Plaintiff asserts in its surreply that the real issue is whether a statutory or legislative basis exists behind prohibiting Plaintiff to recover the full amount of its medical charges after receiving government payments. The statute, however, is not concerned with the desire of health-care providers to receive maximum payment. Rather, it creates a manageable system of Medicaid payment, whereby the validity of a claim is construed at the moment a hospital bills Medicaid. After that point, the hospital is out of the picture. The system is reasonable and clear, and the court may not rewrite the statute for Plaintiff's benefit. Plaintiff does not state a claim upon which relief can be granted.

Medicare Claims

Plaintiff's attempt to collect the entire amount it billed to Medicare also fails. Medicare, like Medicaid, does not allow a health-care provider to pursue further payment after it has billed and received funds from Medicare. *See Rybicki v. Hartley*, 792 F.2d 260 (1st Cir. 1986).

CONCLUSION

For the reasons stated herein, the court grants Defendants' motions to dismiss all counts of Plaintiff's complaint.

IT IS SO ORDERED.

/s/ Harry D. Leinenweber
Harry D. Leinenweber, Judge
United States District Court

DATED: August 19, 1992

STATUTES AND OTHER LAWS INVOLVED

Statutes

42 U.S.C. §1396a. **State plans for medical assistance.**

(a) Contents. A state plan for medical assistance must (25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably except to recover exceeds the cost of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

42 U.S.C. §1396b(o). **Restrictions on authorized payments to States.**

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title [42 USCS §§ 1396 et seq.] to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

Federal regulations

42 C.F.R. §433.136:

. . . "Third party" means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

42 C.F.R. §433.137(a):

A State plan must provide that the requirements of §§433.138 and 433.139 are met for determining legal liability of third parties to pay for services under the plan and for payment of claims involving third parties.

42 C.F.R. §433.139:

(a) *Basic provisions.* (1) For claims involving third party liability that are processed on or after May 12, 1986, the agency must use the procedures specified in paragraphs (b) through (f) of this section. . . .

(b) *Probable liability is established at the time claim is filed.* Unless the agency has received approval to use an alternative method of payment as specified under subparagraph (b)(2) of this section or is required to use the method for paying claims for the situation described in paragraph (b)(3) of this section, the agency must pay claims involving probable third party liability as follows:

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(2) The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the

limit of legal liability if either of the following circumstances is met:

(i) The agency has obtained approval of a waiver of the requirement under paragraph (b)(1) of this section. . . .

(ii) The claim is for labor and delivery and postpartum care. . . .

(3) The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency), consistent with paragraph (f) of this section, if—

(i) The claim is for prenatal care for pregnant women, or preventive pediatric service (including early and periodic screening, diagnosis and treatment services provided for under Part 441, Subpart B) of this chapter, that is covered under the State plan; or

(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV-D agency. The agency prior to making any payment under paragraph (b)(3)(ii) of this section must assure that the following requirements are met:

(A) The State plan specifies whether or not providers are required to bill the third party.

(B) The provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited 30 days from the date of the service and has not received payment from the third party.

(C) The State plan specifies the method used in determining the provider's compliance with the billing requirements.

(c) *Probable liability is not established or benefits are not available at the time claim is filed.* If the probable existence of third party liability cannot be established or

third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule.

(d) *Recovery of Reimbursement.*

(1) If the agency has an approved waiver under paragraph (e) of this section to pay a claim in which the probable existence of third party liability has been established and then seek reimbursement, the agency must seek recovery of reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made.

(2) If the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available.

(3) Reimbursement must be sought unless the agency determines that recovery would not be cost effective in accordance with paragraph (f) of this section.

(e) *Waiver of required use of cost avoidance method.*

(1) The requirement to use the claims payment method specified under paragraph (b)(1) of this section may be waived if—

> (i) The agency submits adequate documentation that the method specified under paragraph (b)(2) of this section is as cost effective as the method required under paragraph (b)(1) of this section to the HCFA Regional Office and requests approval of its use (Administrative costs must be considered in the computation of the cost effectiveness of the State's alternative method); and
>
> (ii) The HCFA Regional Office approves the State's request for a waiver of the requirement. . . .

(f) *Suspension or termination of recovery of reimbursement.*

(1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the

amount it reasonably expects to recover will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.
. . .

42 C.F.R. §433.140(a):

FFP [federal financial participation] is not available in Medicaid payments if—

(1) The agency failed to fulfill the requirements of §§433.148 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

(2) The agency received reimbursement from a liable third party; or

(3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.

42 C.F.R. §447.15:

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.
. . .

42 C.F.R. §447.20:

A State plan must provide for the following:

(a) In the case of an individual who is eligible for medical assistance under the plan for service(s) for which a third party or parties is liable for payment, if the total amount of the established liability of the third party or parties for the service is—

(1) Equal to or greater than the amount payable under the State plan (which includes, when applicable, cost-sharing payments provided for in §§447.53 through 447.56), the provider furnishing the service to the individual may not seek to collect from the individual (or any financially responsible relative or representative of that individual) any payment amount for that service; or

(2) Less than the amount payable under the State plan (including cost sharing payments set forth in §§447.53 through 447.56), the provider furnishing the service to that individual may collect from the individual (or any financially responsible relative or representative of the individual) an amount which is the lesser of—

(i) Any cost-sharing payment amount imposed upon the individual under §§447.53 through 447.56; or

(ii) An amount which represents the difference between the amount payable under the State plan (which includes, where applicable, cost-sharing payments provided for in §§447.53 through 447.56) and the total of the established third party liability for the services.

(b) A provider may not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability for the service(s).

42 C.F.R. §447.21:

If a provider seeks to collect from an individual (or any financially responsible relative or representative of that individual) an amount that exceeds an amount specified under §447.20(a)—

(a) The Medicaid agency may provide for a reduction of any payment amount otherwise due to the provider in addition to any other sanction available to the agency; and

(b) The reduction may be equal to up to three times the amount that the provider sought to collect in violation of §447.20(a).

Illinois Statutes

305 ILCS 5/11-13:

A vendor payment, as defined in Section 2-5 of Article II, shall constitute payment in full for the goods or services covered thereby. Acceptance of the payment by or in behalf of the vendor shall bar him from obtaining, or attempting to obtain, additional payment therefor from the recipient or any other person. . . . Any vendor who accepts a vendor payment and who knowingly obtains or

attempts to obtain additional payment for the goods or services covered by the vendor payment from the recipient or any other person shall be guilty of a Class B misdemeanor.

770 ILCS 35/1. Lien created—Notice of Lien

§1. Every hospital organized for nonprofit, or hospital maintained and operated entirely by a county, rendering service in the treatment, care and maintenance, of such injured person shall have a lien upon all such claims and causes of action for the amount of its reasonable charges at ward rates in such hospital organized for nonprofit, or hospital maintained and operated entirely by a county up to the date of payment of such damages.

Provided however, that the total amount of all liens hereunder shall not exceed one-third of the sum paid or due to said injured person on said claim or right of action, and provided further, that said lien shall in addition include a notice in writing containing the name and address of the injured person, the date of the injury, the name and address of the hospital organized for nonprofit, or hospital maintained and operated entirely by a county, and the name of the party alleged to be liable to make compensation to such injured person for the injuries received, shall be served on both the injured person and the party against whom such claim or right of action exists.

Service shall be made by registered mail or in person.

Illinois Regulations

89 Illinois Administrative Code §140.12(h):

The provider shall agree to . . . Accept as payment in full the amounts established by the Department [of Public Aid]. . . .